



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELITE HEALTHCARE NORTH DALLAS
PO BOX 1210
FRISCO TX 75034

Respondent Name

PEERLESS INSURANCE

Carrier's Austin Representative

Box Number 01

MFDR Tracking Number

M4-13-3277-01

MFDR Date Received

August 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Date 1/29/13 office visit was denied. However, per TDI requirements, office visits in conjunction with work status reports are required for the time taken to complete the work status, of which, was paid."

Amount in Dispute: \$ 768.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request. A copy of the DWC060 request was placed in the carrier representative box on August 20, 2013. As a result, a decision will be issued based on the information contained in the dispute at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 2010 through March 31, 2011	99080-73, 99213, 99080, 99002, 99214, 97140, 97110, 97112, and 99214	\$648.98	\$0.00
January 29, 2013	99213	\$119.22	\$119.22
TOTAL		\$768.20	\$119.22

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
- 16 – Claim/service lacks information which is needed for adjudication
- CV – Documentation to substantiate this charge was not submitted or is insufficient.
- CV – The E&M service documented does not meet the CPT requirements for modifier 025. Service should not be billed separately.
- CV – Reconsideration additional allowance recommended. This bill and submitted documentation have been re-evaluated by clinical validation. An additional allowance is recommended.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service, April 1, 2010 through March 31, 2011?
2. Did the requestor bill in conflict with the NCCI edits for date of service, January 29, 2013?
3. Is the requestor entitled to reimbursement for CPT code 99213 rendered on January 29, 2013?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are April 1, 2010 through March 31, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on August 12, 2013. The dates of service April 1, 2010 through March 31, 2011 are later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B).

The Division concludes that the requestor has failed to timely file dates of service April 1, 2010 through March 31, 2011 with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

2. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The requestor billed CPT codes 99080-73, 99213-25, 97140-GP, 97112-GP and 97110-GP on January 29, 2013. The division completed NCCI edits to identify edit conflicts that would affect reimbursement. No NCCI edits were identified, therefore the disputed service, CPT code 99213-25 will be reviewed pursuant to 28 Texas Administrative Code § 134.203 (c).

3. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

The MAR reimbursement for CPT code 99213 rendered on January 29, 2013 is \$119.22. The requestor seeks reimbursement in the amount of \$119.22, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$119.22.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$119.22 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	<u>November 14, 2013</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.